

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>99</u>	Intermediate (ICF)	<u>99</u>	<u>36,234</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>33,245</u>	<u>1</u>		<u>33,246</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,245</u>	<u>1</u>		<u>33,246</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.75%D. How many bed-hold days during this year were paid by Public Aid?
221 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 1969

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOI # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	275	10,270	68,238	78,783		78,783		78,783			1
2	Food Purchase		235,722		235,722	(20,555)	215,167	(0)	215,167			2
3	Housekeeping		33,256	173,428	206,684		206,684		206,684			3
4	Laundry		182		182		182		182			4
5	Heat and Other Utilities			52,508	52,508		52,508	641	53,149			5
6	Maintenance	32,316	32,868	8,285	73,469		73,469	2,540	76,009			6
7	Other (specify):*											7
8	TOTAL General Services	32,591	312,298	302,459	647,348	(20,555)	626,793	3,181	629,974			8
9	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	361,552	10,100	137,434	509,086		509,086		509,086			10
10a	Therapy			853	853		853		853			10a
11	Activities	47,142	4,806	3,804	55,752		55,752		55,752			11
12	Social Services			44,162	44,162		44,162		44,162			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	408,694	14,906	186,253	609,853		609,853		609,853			16
17	C. General Administration											
17	Administrative			330,000	330,000		330,000	(186,174)	143,826			17
18	Directors Fees											18
19	Professional Services			17,117	17,117	(3,000)	14,117	2,679	16,796			19
20	Dues, Fees, Subscriptions & Promotions			4,763	4,763		4,763	(745)	4,018			20
21	Clerical & General Office Expenses	6,577	6,988	30,606	44,171		44,171	49,428	93,599			21
22	Employee Benefits & Payroll Taxes			76,123	76,123	20,555	96,678		96,678			22
23	Inservice Training & Education											23
24	Travel and Seminar			480	480		480		480			24
25	Other Admin. Staff Transportation			689	689		689	1,341	2,030			25
26	Insurance-Prop.Liab.Malpractice			56,720	56,720		56,720	619	57,339			26
27	Other (specify):*							24,547	24,547			27
28	TOTAL General Administration	6,577	6,988	516,498	530,063	17,555	547,618	(108,305)	439,313			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	447,862	334,192	1,005,210	1,787,264	(3,000)	1,784,264	(105,124)	1,679,140			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

940 CULLOM, D/B/A MARGARET MANOR NORTH
0017178
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	20,555	
2	FOOD		20,555

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	3,000	
19	PROFESSIONAL FEES		3,000

To reclass cost of appealing real estate taxes

Facility Name & ID Number **940 CULLOM, D/B/A MARGARET MANOR NORTH #0017178** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	Depreciation			15,010	15,010		15,010	7,543	22,553			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,212	1,212		1,212	41,862	43,074			32
33	Real Estate Taxes			56,912	56,912	3,000	59,912	2,862	62,774			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	(210,000)				34
35	Rent-Equipment & Vehicles			4,382	4,382		4,382		4,382			35
36	Other (specify):*											36
37	TOTAL Ownership			287,516	287,516	3,000	290,516	(157,733)	132,783			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,995	4,995		4,995		4,995			41
42	Provider Participation Fee			54,351	54,351		54,351		54,351			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			59,346	59,346		59,346		59,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	447,862	334,192	1,352,072	2,134,126		2,134,126	(262,857)	1,871,269			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	4,367	30	9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(0)	2	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties	(275)	21	18
19	Entertainment			19
20	Contributions	(300)	20	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional	(1,363)	20	25
26	Income Taxes and Illinois Personal			26
27	Property Replacement Tax	(203)	21	27
28	Nurse Aide Training for Non-Employees			28
29	Yellow Page Advertising			29
30	Other-Attach Schedule	(3,257)		30
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,031)	\$	30

OHF USE ONLY

48	49	50	51	52
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(261,826)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (261,826)	36
37	(sum of SUBTOTALS (A) and (B))	\$ (262,857)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	CAPITALIZED R&M	(2,010)	6
3	NON-CARE DEPRECIATION	(1,247)	30
4			
5			
6			
7			
8			
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89			
90	Total	(3,257)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(0)											(0)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			641									641	5
6	Maintenance	(2,010)		4,550									2,540	6
7	Other (specify):*													7
8	TOTAL General Services	(2,010)		5,191									3,181	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(330,000)	96,659	47,167							(186,174)	17
18	Directors Fees													18
19	Professional Services			2,679									2,679	19
20	Fees, Subscriptions & Promotions	(1,663)		918									(745)	20
21	Clerical & General Office Expenses	(478)		49,906									49,428	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			1,341									1,341	25
26	Insurance-Prop.Liab.Malpractice			619									619	26
27	Other (specify):*			8,700	8,425	7,422							24,547	27
28	TOTAL General Administration	(2,141)		(265,837)	105,084	54,589							(108,305)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,151)		(260,646)	105,084	54,589							(105,124)	29

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O'Brien	60%	SEE ATTACHED		SEE ATTACHED		
Daniel O'Brien	20%					
Mary O'Brien	20%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 210,000	940 Cullom Building Partnership	100.00%	\$	(210,000)	1
2	V	32 Interest		940 Cullom Building Partnership		25,706	25,706	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 210,000			\$ 25,706	\$ * (184,294)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 641	\$ 641	15
16	V	6 REPAIRS AND MAINT.		MADO MGMT. LP		4,550	4,550	16
17	V	19 PROFESSIONAL FEES		MADO MGMT. LP		2,679	2,679	17
18	V	20 DUES AND SUBSCRIPTIONS		MADO MGMT. LP		918	918	18
19	V	21 CLERICAL AND GENERAL		MADO MGMT. LP		49,906	49,906	19
20	V	25 AUTO EXPENSE		MADO MGMT. LP		1,341	1,341	20
21	V	26 PROPERTY INSURANCE		MADO MGMT. LP		619	619	21
22	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		8,700	8,700	22
23	V	30 DEPRECIATION		MADO MGMT. LP		4,423	4,423	23
24	V	32 INTEREST		MADO MGMT. LP		16,156	16,156	24
25	V	33 REAL ESTATE TAXES		MADO MGMT. LP		2,862	2,862	25
26	V	17 MANAGEMENT FEES	330,000	MADO MGMT. LP			(330,000)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 330,000			\$ 92,795	\$ * (237,205)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4		5 Cost to Related Organization		6	7	8 Difference:	
		Item		Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	\$		MADO MGMT. LP		100.00%	\$ 3,770	\$ 3,770	15
16	V	27	EMP. BEN.-D. O'BRIEN			MADO MGMT. LP			1,298	1,298	16
17	V										17
18	V	17	SALARY-P. O'BRIEN			MADO MGMT. LP			61,111	61,111	18
19	V	27	EMP. BEN.-P. O'BRIEN			MADO MGMT. LP			4,395	4,395	19
20	V										20
21	V	17	SALARY-C. STUMPF			MADO MGMT. LP			31,778	31,778	21
22	V	27	EMP. BEN.-C. STUMPF			MADO MGMT. LP			2,732	2,732	22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$					\$ 105,084	\$ * 105,084	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4		5 Cost to Related Organization		6	7	8 Difference:	
		Item		Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$		MADO MGMT. LP		100.00%	\$	\$	15
16	V	6	REPAIRS AND MAINTENANCE			MADO MGMT. LP					16
17	V	17	ADMINISTRATIVE SALARY			MADO MGMT. LP			47,167	47,167	17
18	V	21	CLERICAL SALARY			MADO MGMT. LP					18
19	V	27	GEN. ADMIN. - EMP. BEN.			MADO MGMT. LP			7,422	7,422	19
20	V	30	DEPRECIATION-WAREHOUSE			MADO MGMT. LP					20
21	V	33	REAL ESTATE TAXES			MADO MGMT. LP					21
22	V										22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$					\$ 54,589	\$ * 54,589	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 62,460	Windy City Nursing		\$ 62,460	\$
16	V	10 Nursing	137,435	Windy City Nursing		137,435	
17	V	12 Social Service	44,162	Windy City Nursing		44,162	
18	V	21 Office	46,372	Windy City Nursing		46,372	
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 290,429			\$ 290,429	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANC # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel O'Brien	Owner	Administrative	20.00	see attached	3	7.50	Alloc MADO	\$ 3,770	17-7	1
2	Peter O'Brien	Owner	Administrative	60.00	see attached	11	18.33	Alloc MADO	61,111	17-7	2
3	Charles Stumpf	Relative	Asst. Admin.		see attached	11	24.44	Alloc MADO	31,778	17-7	3
4	James West	Relative	Clerical		see attached	5.5	13.75	Alloc MADO	6,945	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 103,604		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1									1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	243,330	5	\$ 4,695	\$	33,246	\$ 641	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	243,330	5	33,305		33,246	4,550	2
3	19 PROFESSIONAL FEES	PATIENT DAYS	243,330	5	19,610		33,246	2,679	3
4	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	243,330	5	6,715		33,246	918	4
5	21 CLERICAL AND GENERAL	PATIENT DAYS	243,330	5	365,265	298,189	33,246	49,906	5
6	25 AUTO EXPENSE	PATIENT DAYS	243,330	5	9,811		33,246	1,341	6
7	26 PROPERTY INSURANCE	PATIENT DAYS	243,330	5	4,530		33,246	619	7
8	27 GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	243,330	5	63,675		33,246	8,700	8
9	30 DEPRECIATION	PATIENT DAYS	243,330	5	32,369		33,246	4,423	9
10	32 INTEREST	PATIENT DAYS	243,330	5	118,247		33,246	16,156	10
11	33 REAL ESTATE TAXES	PATIENT DAYS	243,330	5	20,949		33,246	2,862	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 679,171	\$ 298,189		\$ 92,795	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	30,158	30,158	3	3,770
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	10,385		3	1,298
3									3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	250,000	250,000	11	61,111
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	17,978		11	4,395
6									6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	11	31,778
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,175		11	2,732
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 449,696	\$ 410,158		\$ 105,084	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION	1	1,218	1,218			1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION	1	41	41			2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION	5	303,237	303,237		47,167	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION	3	80,490	80,490			4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION	5	51,678	51,678		7,422	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION	1	1,082	1,082			6
7	33	REAL ESTATE TAXES	AVG. HOURS WORKED	1	1,865	1,865			7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 439,611	\$ 439,611		\$ 54,589	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Windy City Nursing
 Street Address 1541 N. Wells St.
 City / State / Zip Code Chicago, IL 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 62,460	1
2	10	Nursing	Direct Allocation					137,435	2
3	12	Social Service	Direct Allocation					44,162	3
4	21	Office	Direct Allocation					46,372	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 290,429	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANO # 0017178 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	BLDG COMPANY	X		MORTGAGE			\$	216,854			\$	25,706	1
2													2
3													3
4													4
5													5
	Working Capital												
6	TIF Co.		X	Insurance Financing				5,071				1,212	6
7													7
8													8
9	TOTAL Facility Related						\$	221,925			\$	26,918	9
	B. Non-Facility Related*												
10	Supplemental Schedule												10
11													11
12	Allocation Mado Management	X										16,156	12
13													13
14	TOTAL Non-Facility Related						\$				\$	16,156	14
15	TOTALS (line 9+line14)						\$	221,925			\$	43,074	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR N# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **940 CULLOM, D/B/A MARGARET MANOR NORTH**# **0017178**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	57,296	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	57,063	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(233)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	60,006	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	3,000	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	62,773	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	56,144	8
	1996	54,918	9
	1997	53,616	10
	1998	54,568	11
	1999	54,201	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

REAL ESTATE TAX ACCRUAL = \$54,201 X 110.7% = \$60,006

Allocated from Mado Management \$2862 (included in line 2)

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>20,000</u>	1
2					2
3	TOTALS			\$ 20,000	3

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1969		\$ 105,000	\$	20	\$	\$	\$ 105,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		25,336		20			25,336	9
10	Various		1981		2,395		20			2,395	10
11	Various		1984		1,478	59	20	74	15	1,304	11
12	Various		1985		4,127	159	20	206	47	3,180	12
13	Various		1986		3,495	147	20	175	28	2,520	13
14	Various		1987		9,180	291	20	459	168	4,589	14
15	Various		1988		20,920	664	20	1,046	382	10,132	15
16	Various		1990		62,014	1,624	20	3,101	1,477	24,228	16
17	Various		1991				20			28,600	17
18	Various		1992		33,940	1,783	20	1,697	(86)	2,736	18
19	Various		1993		13,374		20	510	510	3,297	19
20	Various		1994		14,277		20	714	714	3,799	20
21	Various		1995		7,210		20	361	361	1,901	21
22	INTERCOM SYSTEM		1996		561		20	28	28	121	22
23	DOORS		1996		2,720	70	20	136	66	589	23
24											24
25	PAGE 12-I REP TOTALS				42,136	1,470		1,443	(27)	8,293	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				331,758	2,980		2,980		241,478	34
35	PAGE 12A TOTALS				58,223	1,671		2,913	1,242	9,466	35
36	TOTAL (lines 4 thru 35)				\$ 738,144	\$ 10,918		\$ 15,843	\$ 4,925	\$ 478,964	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS			1996	6,646	170	20	332	162	1,411	9
10	VARIOUS			1996	4,247	109	20	212	103	848	10
11	DOOR			1996	795		20	40	40	190	11
12	FLOOR TILE			1996	540		20	27	27	124	12
13	RADIATOR REPAIRS			1996	1,058		20	53	53	243	13
14	LOCKING SYSTEM			1996	731		20	37	37	179	14
15	DOORS			1996	5,892	151	20	295	144	1,475	15
16	DOORS			1996	4,100	105	20	205	100	1,025	16
17	FIRE EQUIP REPAIRS			1997	1,879		20	94	94	306	17
18	TUCKPOINTING			1997	1,100		20	55	55	188	18
19	ELEVATOR DOORS			1997	1,100		20	55	55	174	19
20	FIRE EQUIP REPAIRS			1997	1,004		20	50	50	167	20
21	FIRE EQUIP REPAIRS			1997	1,835		20	92	92	307	21
22	CHIMNEY REPAIRS			1997	4,600		20	230	230	786	22
23	J&L - DOORS			1998	2,640	132	20	132		308	23
24	HOLLUB-PUMP & MOTOR			1998	1,870	94	20	94		282	24
25	REPLACED LEAKING PIP			1999	541	27	20	27		32	25
26	ROOF & DOWNSPOUT REP			1999	5,790	290	20	290		532	26
27	REPLACED LEAKING PIP			1999	1,335	67	20	67		73	27
28	CONDENSATE PUMP			1999	1,543	77	20	77		96	28
29	WATER HEATER			1999	675	34	20	34		43	29
30	4 SETS VERTICAL BLIN			1999	1,092	55	20	55		69	30
31	3 PUSH BUTTON HAND D			1999	1,005	50	20	50		92	31
32	REPAIR HTG UNIT-CIRC			1999	2,200	110	20	110		211	32
33	ROOFING MATERIALS			1999	1,039	52	20	52		104	33
34	METAL DOORS			1999	2,219	111	20	111		139	34
35	BLINDS			1999	747	37	20	37		62	35
36	TOTAL (lines 4 thru 35)				\$ 58,223	\$ 1,671		\$ 2,913	\$ 1,242	\$ 9,466	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING & DECORATING			1999	772	39	20	39		68	9
10	ELECTRICAL FIXTURES			2000	3,083	90	20	90		90	10
11	A/C'S			2000	1,126	37	20	37		37	11
12	WASHROOM FLOOR			2000	1,980	50	20	50		50	12
13	ELECTRICAL INSTALL			2000	3,685	77	20	77		77	13
14	BLINDS			2000	2,584	32	20	32		32	14
15	ROOF REPAIR			2000	6,250	52	20	52		52	15
16	PUMP			2000	1,145	5	20	5		5	16
17	MASONRY WORK			2000	523	2	20	2		2	17
18	PARTS GE MOTOR			2000	852	36	20	36		36	18
19	BOILER			2000	15,125	630	20	630		630	19
20	WATER LINES			2000	11,850	445	20	445		445	20
21	ELEVATOR			2000	7,700	289	20	289		289	21
22	ELEVATOR			2000	8,144	305	20	305		305	22
23	REMODELING			2000	4,184	122	20	122		122	23
24	FIRE ALARM SYSTEM			2000	4,979	125	20	125		125	24
25	A/C'S			2000	10,894	363	20	363		363	25
26	BLINDS			2000	8,413	281	20	281		281	26
27											27
28	VARIOUS			1969	23,125					23,125	28
29	VARIOUS			1970	19,000					19,000	29
30	VARIOUS			1972	20,000					20,000	30
31	VARIOUS			1973	16,751					16,751	31
32	VARIOUS			1974	5,550					5,550	32
33	VARIOUS			1975	118,165					118,165	33
34	VARIOUS			1978	20,810					20,810	34
35	VARIOUS			1979	15,068					15,068	35
36	TOTAL (lines 4 thru 35)				\$ 331,758	\$ 2,980		\$ 2,980	\$	\$ 241,478	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
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21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
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24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
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23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
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23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
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23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
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32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	Alloc Mado	\$ 28,320	\$ 1,030		\$ 809	\$ (221)	\$ 4,046	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - Mado Management			1995	657	153	20	33	(120)	181	9
10	Allocation - Mado Management			1993	10,787	287	20	539	252	4,004	10
11	Allocation - Mado Management			2000	2,372		20	62	62	62	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 42,136	\$ 1,470		\$ 1,443	\$ (27)	\$ 8,293	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH# 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NC # 0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 55,216	\$ 5,906	\$ 5,523	\$ (383)		\$ 23,986	37
38	Current Year Purchases	11,616	841	30	(811)		30	38
39	Fully Depreciated Assets	121,505		250	250		121,505	39
40								40
41	TOTALS	\$ 188,337	\$ 6,747	\$ 5,803	\$ (944)		\$ 145,521	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility - Admin.	Ford Wagon 1990	1995	\$ 5,440	\$ 521	\$ 907	\$ 386		\$ 5,440	42
43	Facility Business	Ford Wagon	1988	19,707					16,485	43
44										44
45										45
46	TOTALS			\$ 25,147	\$ 521	\$ 907	\$ 386		\$ 21,925	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 971,628	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 18,186	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 22,553	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 4,367	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 646,410	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	LIMP - Capital Projection	\$ 24,936	\$ 1,247	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 24,936	\$ 1,247	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

940 CULLOM, D/B/A MARGARET MANOR NORTH
0017178
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Margaret Manor North	39,487	2,954	3,950	996	19,237
Mado Management	15,729	2,952	1,573	(1,379)	4,749
TOTALS	55,216	5,906	5,523	(383)	23,986

LINE 29: CURRENT YEAR

Margaret Manor North	10,667	841	30	(811)	30
Mado Management	949				
TOTALS	11,616	841	30	(811)	30

LINE 30: FULLY DEPRECIATED

Margaret Manor North	121,505		250	250	121,505
Mado Management					
TOTALS	121,505		250	250	121,505

TOTALS (Should Tie to Totals on Page 13)

Margaret Manor North	171,659	3,795	4,230	435	140,772
Mado Management	16,678	2,952	1,573	(1,379)	4,749
TOTALS	188,337	6,747	5,803	(944)	145,521

Facility Name & ID Number	940 CULLOM, D/B/A MARGARET MANOR NORTH	#	0017178	Report Period Beginning:	01/01/00	Ending:	12/31/00
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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 2001 §

13. _____ /2002 \$ _____

14. /2003 \$

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 4,382 Description: Copier \$1527, Ice Machine \$1049, Air Cleaner \$913, Vending Machine \$893

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18					18
19					19
20					20
21	TOTAL		\$	0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

#

0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

Special Services - Supplies (Column 6 - Other)	Amount
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	

Outside Therapies (Column 5 - Other)		Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 947	\$ 947	1
2 Cash-Patient Deposits	2,903	2,903	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	796,956	796,956	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	14,240	14,240	6
7 Other Prepaid Expenses	460	460	7
8 Accounts Receivable (owners or related parties)	3,068,036	3,068,036	8
9 Other(specify): See supplemental schedule	718	23,468	9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 3,884,260	\$ 3,907,010	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		20,000	13
14 Buildings, at Historical Cost		105,000	14
15 Leasehold Improvements, at Historical Cos	623,025	623,025	15
16 Equipment, at Historical Cost	197,298	197,298	16
17 Accumulated Depreciation (book methods)	(532,480)	(637,480)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	4,500	4,500	19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):	1,643	1,643	22
23 Other(specify): See supplemental schedule			23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 293,986	\$ 313,986	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 4,178,246	\$ 4,220,996	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 496,344	\$ 496,344	26
27 Officer's Accounts Payable	71,702	71,702	27
28 Accounts Payable-Patient Deposits	17,328	17,328	28
29 Short-Term Notes Payable	5,071	5,071	29
30 Accrued Salaries Payable	18,312	18,312	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	60,006	60,006	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes	(1,231)	(1,231)	35
Other Current Liabilities(specify):			
36 See supplemental schedule	25,234	25,234	36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 692,766	\$ 692,766	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		216,854	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule			43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$	\$ 216,854	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 692,766	\$ 909,620	46
TOTAL EQUITY (page 18, line 24)	\$ 3,485,480	\$ #REF!	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 4,178,246	\$ #REF!	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH # 0017178

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

	Amount	Amount
Employee Advances	718	718
Real Estate Tax Escrow		22,750

<u>718</u>	<u>23,468</u>
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OTHER NON CURRENT ASSETS:

<u> </u>	<u> </u>
<u> </u>	<u> </u>

OTHER CURRENT LIABILITIES:

	Amount	Amount
Accrued Expenses	(291)	(291)
Exchange	25,525	25,525

<u>25,234</u>	<u>25,234</u>
---------------	---------------

OTHER NON CURRENT LIABILITIES:

<u> </u>	<u> </u>
<u> </u>	<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,948,759	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,948,759	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	536,721	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 536,721	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,485,480	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number	940 CULLOM, D/B/A MARGARET M/#	0017178	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	2,948,759
----------------------------	-----------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

2,948,759

Equity(Deficit) from Page 17 Col 1

3,485,480

Related Party

Equity(Deficit)

-174104

Income

0

(174,104)

Combined Equity - End of Year

3,311,376

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NOI # 0017178 Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,670,847	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,670,847	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,670,847	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	647,348	31
32	Health Care	609,853	32
33	General Administration	530,063	33
	B. Capital Expense		
34	Ownership	287,516	34
	C. Ancillary Expense		
35	Special Cost Centers	4,995	35
36	Provider Participation Fee	54,351	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,134,126	40
41	Income before Income Taxes (line 30 minus line 40)**	536,721	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 536,721	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [not complete](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,311	3,657	64,505	17.64	3
4	Licensed Practical Nurses	63	111	1,326	11.95	4
5	Nurse Aides & Orderlies	34,519	37,366	269,767	7.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,227	3,533	36,022	10.20	9
10	Activity Assistants	1,921	1,934	11,120	5.75	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	48	48	275	5.73	15
16	Dishwashers					16
17	Maintenance Workers	3,587	3,986	32,316	8.11	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,136	1,144	6,577	5.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,413	2,496	25,954	10.40	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	50,225	54,275	\$ 447,862 *	\$ 8.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	173	\$ 4,325	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	86	3,804	11-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Rehab Consultant</u>	53	853	10A-3	46
47	<u>Dietary Contract Services</u>	monthly	63,913	1-3	47
48	<u>Outside Labor - Social Service</u>	3,878	44,162	12-3	48
49	TOTAL (lines 35 - 48)	4,190	\$ 117,057		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,497	\$ 107,977	10-3	50
51	Licensed Practical Nurses	2,157	29,322	10-3	51
52	Nurse Aides	22	135	10-3	52
53	TOTAL (lines 50 - 52)	7,676	\$ 137,434		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership %	Amount	D. Employee Benefits and Payroll Taxes	Description	Amount	F. Dues, Fees, Subscriptions and Promotions	Description	Amount
Name	Function	%	\$						
				Workers' Compensation Insurance		\$ 7,568	IDPH License Fee		\$ 400
				Unemployment Compensation Insurance		5,044	Advertising: Employee Recruitment		1,089
				FICA Taxes		33,197	Health Care Worker Background Check (Indicate # of checks performed _____) _____ 20)		204
				Employee Health Insurance		26,907	License & Fees		1,407
				Employee Meals		20,555	Advertising & Promotion		1,363
				Illinois Municipal Retirement Fund (IMRF)*			Allocated from Mado Management		918
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	Other Employee Benefits		3,355			
B. Administrative - Other				401K Employees		52			
Description			Amount						
Management Fees - Mado Management			\$ 330,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,000						
C. Professional Services	Type		Amount	TOTAL (agree to Schedule V, line 22, col.8)		\$ 96,678			
Vendor/Payee				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Health Data Systems	Data Processing		\$ 3,033	Description	Line #	Amount	Description		Amount
Personnel Planners	Unemployment Consultant		560			\$	Out-of-State Travel		\$
Frost, Ruttenberg & Rothblatt	Accounting		8,405						
Wolf & Co.	Accounting		2,119				In-State Travel		
LaSalle Appraisal	Appraisal		3,000						
							Seminar Expense		480
							Entertainment Expense	()
							(agree to Sch. V,		
							line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 17,117	TOTAL		\$	TOTAL		\$ 480

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number 940 CULLOM, D/B/A MARGARET MANOR NORTH

0017178

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,351
This amount is to be recorded on line 42 of Schedule V _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 20,555 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw